

**CAUSES OF MATERNAL MORTALITY IN UGANDA: LEGAL,
SOCIOECONOMIC, AND HEALTHCARE PERSPECTIVES**

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Declaration

I, **Atuheire Elizabeth**, declare that this research dissertation titled "*Causes of Maternal Mortality in Uganda: Legal, Socioeconomic, and Healthcare Perspectives*" is entirely my original compilation and has never been submitted to any university for the award of any degree

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ABSTRACT

This study examined socio-economic and legal determinants of maternal mortality in Uganda focusing on the effectiveness of existing healthcare policies and insurance coverage among women. The study was motivated by the persistence of high maternal mortality levels despite Uganda's adoption of multiple legal systems with a goal to improve maternal well-being. The study sought to assess the legislation that governs maternal health, analyze the role of socio-economic determinants in maternal deaths, and discuss the effect of healthcare policies in Uganda. A mixed-methods study design was used, with the reliance on secondary data from Uganda's national health surveys and legal frameworks, and logistic regression was utilized to assess the relationship between maternal death and socio-economic determinants.

Multiple harsh gaps and inequalities in maternal services were revealed in the findings of the study. On legal frameworks, whereas policies exist, such as the Uganda Constitution (1995), the National Health Policy (2010), and the Uganda Vision 2040, the implementation level is low. On socio-economic determinants' contribution, the research showed that levels of education were a strong determinant of the risk for maternal mortality (e.g., odds ratio for women who were not educated = 5.511, $p = 0.000$). Wealth status was also significant, with the poorest women being at higher risk of death from pregnancy-related causes (odds ratio = 1.575, $p = 0.000$). Age was also a significant predictor, with women aged 45–49 years having the highest risk (odds ratio = 13.601, $p = 0.000$). Health insurance coverage was drastically low, with less than 5% of women under health insurance, and few were reported to be aware of their maternal health rights.

In general, the study calls for the strengthening of the enforcement of current legal frameworks, the improvement of access to maternal health services, and the narrowing of socio-economic inequalities. Policy recommendations include increased investment in the infrastructure for maternal health, prepping more skilled birth attendants, and bringing maternal health coverage into national health insurance plans. Practical recommendations include road enhancement and emergency care provision. Areas found lacking in research include longitudinal outcomes studies and more research into cultural and institutional determinants of obstacles to maternal care.

Keywords: maternal mortality, legal context, socio-economic status, health care policy, insurance, Uganda, logistic regression.

Dedication

I dedicate this research to my beloved children Victory Nagudi Kezabu and Brielle Muzaki Keirigidwa, my mother Alice .T. Begumanya, Dr Johnson Byabasheija, my siblings, Patience, Marion, Emilly, Karen, Hope, my nieces and nephews. I deeply hold you in my heart and dearly love you.

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CHAPTER ONE

1.0 Introduction

This chapter contains a background of the study, a problem statement, objectives, study hypothesis, research questions, scope and significance of the study, and in addition forms the ground for the conceptual framework for analysis.

1.1 Background

Maternal mortality is still holding on to its head as one of the major health problems with about 800 women dying daily from preventable causes related to pregnancy and childbirth. The global maternal mortality ratio has decreased by 34% between 2000 and 2020, from 339 to 223 deaths per 100,000 live births¹, but an annual reduction rate of 2.1% is insufficient to meet the Sustainable Development Goal's 11.6% target. In this context, legal and policy frameworks have been extremely significant. Restrictive reproductive laws are reported to be linked to high maternal mortality rates as in El Salvador². In a different sense, Argentina has moved ahead legally reproductive rights, yet budget cuts have also affected the provision of necessary services in this country³.

Sub-Saharan Africa has a disproportionate share of the global burden of maternal death, whereby approximately two-thirds were recorded in the region in 2020.⁴ The region's MMR is still grossly elevated compared to global average MMRs, which is reported to be 292 per 100,000 live births in rural areas versus 100 per 100,000 in urban settings (UNICEF, 2020). Examples of indirect contributors include poor health systems, shortage of skilled birth attendants and systemic socio-economic challenges⁵. Legal and policy interventions are central to this discourse. Uganda's maternal health policies are, for example, under review for problems in their design that may affect effectiveness⁶. Aid from the United States to African countries could also be hampered by a reinstatement of policies such as the global gag rule, which would

¹UNICEF. (2020). *Maternal mortality: UNICEF DATA*. <https://data.unicef.org/topic/maternal-health/maternal-mortality/> accessed on 10th march 2025

² Ugarte and others ., 2022

³ Keogh, S. C., Binstock, G., Tort, M. P., & Singh, S. (2025). <https://doi.org/10.1371/journal.pgph.0003526> 4th April 2025.

⁴ WHO. (2023, February 23) <https://www.who.int/publications/i/item/9789240068759> accessed on 10th March 2025

⁵ Avigad and others., 2024

⁶ Mukuru and others., (2021). <https://doi.org/10.34172/ijhpm.2021.127> accessed on 10th March 2025

subsequently undermine funding streams for reproductive health services across African countries facing already daunting threats to maternal health⁷.

Maternal mortality continues to be a big problem in Uganda. The study on institutional maternal death in Kampala between 2016 and 2021 found that 84% of the maternal deaths were classified as preventable. The major causes were obstetric haemorrhages, hypertensive disorders, and infections⁸In 95% of the cases, health facility delays were noted, indicating systemic problems in service delivery (Birabwa and others 2024). Legal and policy architecture in Uganda have been condemned for design flaws which would obstruct progress made in reducing maternal mortality (Mukuru and others 2021). The quality of routine data to measure facility-based maternal mortality has been challenged, thus suggesting that better data collection and monitoring systems are needed (Birabwa and others 2024). To provide equally quality maternal health services, extensive legal and policy reforms, investments in health infrastructure and training of the workforce is still necessary in the country.

1.2 Statement of the problem

While global and regional commitments exist to reduce the incidence of maternal mortality, Uganda still has issues with inadequate infrastructure, unavailability of skilled attendants, poverty, illiteracy and gender barriers restricting women's access to quality health services during childbirth. The maternal mortality ratio (MMR) has been estimated to be 189 deaths per 100,000 live births according to the Uganda Demographic and Health Survey 2022 (UDHS) (UBOS, 2023). Article 22 (2) of the Constitution of Uganda⁹ provides for protection of maternal health rights, however, lack of enforcement and inadequate legal regimes hinder their attainment.¹⁰ Besides, the criminalization of certain reproductive health services along with restrictive abortion laws contribute to unsafe pregnancy and unnecessary maternal deaths thereby worsening the situation¹¹.

⁷Sully, E. A., & Friedrich-Karnik, A. (2024). Evidence for ending the global gag rule: a multiyear study in two countries. <https://doi.org/10.1363/2024.300502> accessed on the 5th April 2025

⁸ Birabwa, and others., (2024). The quality of routine data for measuring facility-based maternal mortality in public and private health facilities in Kampala City, Uganda. *Population Health Metrics*, 22(1). <https://doi.org/10.1186/s12963-024-00343-z> accessed on 3rd May 2025

⁹ .The Constitution of The Republic of Uganda 1995 (Ammended)

¹⁰ Mukuru others. (2021). <https://doi.org/10.34172/ijhpm.2021.127> accessed 10th March 2025

¹¹ Kheyfets and others. (2023). doi: 10.3389/fpubh.2023.1291668 10th March 2025

The issue continues to persist even in the presence of statutory and policy frameworks, thereby raising an urgent need for intervention into the gaps that appear critical. Compound factors in the dilemma include poor health sector governance and limited funds, as well as inequalities in access to health care between urban and rural women (WHO, 2023). These add to some of the socio-economic hindrances like access to education, cultural mores opposed to skilled birth attendance, and poverty that leads women to deliver at home¹². This research identifies legal and policy gaps and makes recommendations towards improving health outcomes. This would also mean contributing to reducing maternal deaths and achieving Sustainable Development Goals.

1.3 Study Objectives

1.3.1 General Objective

To examine the causes of maternal mortality in Uganda from legal, socioeconomic, and healthcare perspectives.

1.3.2 Specific Objectives

- i. To examine the legal framework governing maternal health in Uganda.
- ii. To assess the role of socioeconomic factors in maternal mortality in Uganda.
- iii. To analyse the effectiveness of Uganda's healthcare policies on maternal mortality.

1.4 Research Questions

- i. What are the legal frameworks governing maternal health in Uganda, and how do they impact maternal mortality?
- ii. How do socio-economic factors contribute to maternal mortality in Uganda?
- iii. How effective are Uganda's healthcare policies in addressing maternal mortality?
- iv. How have the stakeholders such as the government, NGOs, etc. have practically tried to end Maternal Mortality?

1.5 Significance of the study.

This study is valuable in the sense that it explores the legal, socio-economic, and healthcare-related causes of maternal mortality in Uganda with a view to evidence that may influence policy development and legal reforms to tackle maternal deaths. In analysing the existing legal frameworks, health policies, and socio-economic barriers, the study provides evidence-based recommendations to lawmakers, policymakers, healthcare providers, and advocacy groups for

¹² Ibid

strengthening maternal health services. This study adds to academic literature by filling the research gaps on the nexus between law, policy and maternal health, ultimately reinforcing Uganda's commitments under various global commitments such as the Sustainable Development Goals (SDG 3) on maternal health and well-being.

1.6 Justification for need of this study.

As it stands, maternal mortality is a major public health and human rights challenge in Uganda, notwithstanding prevailing policies and legal provisions enshrined to reduce maternal deaths. The continued occurrence of preventable maternal deaths indicates that there is need for an approach that would address gaps in the enforcement of the law, delivery of healthcare services and socio-economic inequalities. This study is justified, as it seeks to analyse these factors critically, identify the gaps that exist in the present maternal health framework and give recommendations that can be implemented. Findings from this study provides key advocacy points for stronger legal protection, effective policies, and better access to maternal healthcare services so as to ultimately reduce maternal mortality and enhance women's reproductive rights in Uganda.

1.7 Study Scope

1.7.1 Time scope

This study covers the period from 2015 to 2025, constituting up to a decade within which interventions have been put in place in terms of policy, legal reform, and health strategy to tackle maternal mortality in Uganda. The study period, for instance, captures major events such as the implementation of Uganda's National Development Plan III (2020/21–2024/25) and other commitments under Sustainable Development Goals such as SDG 3.1 which aims at halving the global maternal mortality ratio. Research is going to take place within the period of three months from January 2025 to April 2025.

1.7.2 Geographical scope

The study looks at Uganda focusing on areas with the highest maternal death rate according to the 2022 Uganda Demographic and Health Survey (UDHS). Maternal health problems may exist all over the country but differences in access to healthcare in urban versus rural areas warrant a closer look at regions such as Karamoja, Acholi, and Busoga, where maternal mortality continues to be critically high. These regions are characterized by the underutilization of health infrastructures, maternal health services that are grossly wanting, and socio-economic barriers that facilitate maternal deaths.

1.7.3 Subject/thematic scope

The study investigates the causes of maternal mortality in Uganda with reference to the role of legal, socio-economic, and health factors. The study also appreciates Uganda's Constitution and Public Health Act in contribution to international treaties and health care policies such as National Health Policy. The study equally accounts for the socioeconomic factors responsible for the cause and effects of increment in maternal mortality rate in the country.

1.8 Literature review

1.8.1 Socioeconomic barriers affecting maternal health

Maternal health outcomes are influenced by socioeconomic factors like poverty, education, and cultural practices in a way that can either facilitate or prevent access to maternal care services (WHO, 2023). In Uganda, poverty is one of the leading barriers to maternal health, and many women in rural areas cannot afford antenatal care, skilled birth attendants, or emergency obstetric services (UBOS, 2022). Evidence shows that low-income women have higher maternal mortality because they cannot afford healthcare costs, transport to health facilities, and essential medicines¹³ Uganda Demographic and Health Survey (UDHS) 2022 reports that a third of pregnant women cannot afford the cost of skilled delivery care increasing mortality and complications (MoH, 2022). Financial burden at the household level ensures that the majority of women access services from traditional birth attendants who may lack the skills needed to manage maternal emergencies thus enhancing mortality (Dahab & Sakellariou, 2020).

Maternal education and health are crossed and enmeshed: Many women do not know maternal services and exhibit inappropriate health-seeking behavior with low literacy levels (Mahmood, 2022). The evidence indicates that pregnant women tend to go to antenatal care, receive delivery in facilities, receive postnatal care according to the education level obtained (Ndugga others, 2020). Educated women are more likely to access antenatal care, deliver in facilities, and receive postnatal services than uneducated women (Negero and others 2023). As many as 54% of uneducated women received antenatal care from trained healthcare providers compared to 89% in those with secondary or higher education, based on the UDHS (2022) (MoH, 2022). Gender roles and cultural attitudes tend to make matters worse automatically because some

¹³Thomas and Dahab, R., & Sakellariou, D. (2020). Barriers to accessing maternal care in Low income countries in Africa: A systematic review. *International Journal of Environmental Research and Public Health*, 17(12), 4292. <https://doi.org/10.3390/ijerph17124292> accessed on the 15th April 2025

communities are against hospital deliveries and opt for home delivery because of cultural reasons and suspicion against the use of modern health centers (Aynalem and others 2023; Adatara and others 2019). In the case of Uganda, that illiterate status plus cultural prejudice is still downplaying the priority given to maternal health interventions (Magunda and others. 2023).

Maternal health choices by women are also interfered with by gender disparity and limited decision-making authority (Teshale and others. 2025; Kalindi and others. 2023). In numerous Ugandan households, healthcare costs are raised by men as a bill thereby causing delays in seeking maternal health services¹⁴. Due to an ingrained patriarchal system, women are oftentimes denied independence, forcing them to seek their husbands' authorization even for access to contraception, emergency obstetric care, or skilled birth attendants¹⁵. As per UDHS (2022), 25% of females were of the opinion that their husbands/partners were the absolute decision-makers of their healthcare system thereby leading to delays in seeking maternal services critical in nature (MOH, 2022). In order to address these socio-economic barriers, possible interventions include community sensitization, financial support programs, and policies promoting gender equity in health care decision-making.

1.8.2 Effectiveness of Uganda's healthcare policies in reducing maternal deaths

In Uganda, various healthcare policies aimed at curbing maternal mortality have had limited effects on account of systemic challenges such as underfunding, poor implementation, and disparities in service delivery¹⁶. The National Health Policy and the Reproductive Health Policy put maternal health at the forefront, making provisions for free maternal services, skilled birth attendance, and emergency obstetric care (WHO, 2023). Regardless, the Uganda Health Sector Development Plan (2020-2025) states that policies aside, maternal mortality remains high, with the UDHS (2022) putting that at a maternal mortality ratio of 336 deaths per 100,000

¹⁵ Birabwa, and others., (2024). *The quality of routine data for measuring facility-based maternal mortality in public and private health facilities in Kampala City, Uganda. Population Health Metrics*, 22(1). <https://doi.org/10.1186/s12963-024-00343-z> Accessed 15th April 2025

live births¹⁷. Corruption, inadequate maternal health policies, and inadequate infrastructure hinder the growth of demand for improved maternal health outcomes¹⁸.

The Ugandan government has implemented various interventions, including the free provision of maternal healthcare services in public health facilities¹⁹. Nevertheless, various studies have indicated that these services are also threatened by shortages of requisite medicines and inadequate personnel to provide reasonable quality of services²⁰. In fact, according to the World Bank (2023), only 63 percent of health facilities in Uganda possessed such resources as would allow the provision of basic maternal healthcare, and only 47 percent could handle emergency obstetric complications. Corruption and informal fees in public hospitals further deter many pregnant women from seeking viable care in those establishments, forcing them into private facilities often beyond the financial reach of low-income households²¹.

A further challenge is uneven healthcare provision in urban and rural settings²². Most urban hospitals have well-equipped maternal health units, whereas rural health centers are often without skilled personnel, equipment, and even ambulance services; hence, maternal deaths are more frequent in rural communities²³. Beyond sustaining this imbalance through establishing

¹⁷ UBOS. (2023). *UGANDA DEMOGRAPHIC AND HEALTH SURVEY (UDHS) 2022: Uganda Bureau of Statistics*. <https://rb.gy/ir7by2> accessed 25th April 2025

¹⁸ Naher, N., Hoque, R., Hassan, M. S., Balabanova, D., Adams, A. M., & Ahmed, S. M. (2020). *The influence of corruption and governance in the delivery of frontline health care services in the public sector: a scoping review of current and future prospects in low and middle-income countries of south and south-east Asia*. *BMC Public Health*, 20(1). <https://doi.org/10.1186/s12889-020-08975-0> Accessed on the 22nd April 2025

¹⁹ MoH. (2022, August 1). *Sexual and Reproductive Health | MOH Knowledge Management Portal*. https://library.health.go.ug/category/sexual-and-reproductive-health?f%5B0%5D=category%3A321&f%5B1%5D=category%3A323&f%5B2%5D=category%3A405&f%5B3%5D=doc_type%3A11&f%5B4%5D=doc_type%3A12&f%5B5%5D=doc_type%3A392&filter=&sort_by=title accessed on 28th April 2025

²⁰ Haki, A. N. (2023). *CEHURD and 2 others v the Attorney General – Constitutional Petition No 16 of 2011 – JUDGMENT*. Retrieved March 8, 2025, from <https://rb.gy/7elp6k>

²¹ Camacho, G. (2023). *Corruption risks in maternal and perinatal health*. Transparency International Knowledge Hub. <https://knowledgehub.transparency.org/assets/uploads/helpdesk/Corruption-risks-in-maternal-and-perinatal-health.pdf> accessed 10th March 2025

²² Magunda, A., Ononge, S., Balaba, D., Waiswa, P., Okello, D., Kaula, H., Keller, B., Felker-Kantor, E., Mugerwa, Y., & Bennett, C. (2023). *Maternal and newborn healthcare utilization in Kampala urban slums: perspectives of women, their spouses, and healthcare providers*. *BMC Pregnancy and Childbirth*, 23(1). <https://doi.org/10.1186/s12884-023-05643-0> accessed March 15th 2025

²³ UNFPA. (2023). *TRANSFORMING LIVES, INSPIRING CHANGE ANNUAL REPORT 2023*. In UNFPA Uganda. Url: <https://rb.gy/ea9x3> retrieved 20th April 2025

community health programs and training midwives, slow progress is also due to funding gaps²⁴. There is a need for increased resources to build maternal health infrastructure, more vigorous enforcement of policies and community interventions in the healthcare policies of Uganda in order to deal with the access barriers to maternal healthcare.

1.8.3 Gaps in Literature

Findings with respect to maternal mortality in Uganda tend to remain scanty, especially when the interrelations of legal, policy and socioeconomic perspectives are considered. While maternal deaths are related to factors such as poverty, education, and gender-based inequalities, there is little information on Uganda's maternal health laws' enforcement and effectiveness. Furthermore, there is a great absence of investigations into the implementation of healthcare policies at the community level, notably in rural areas.

1.9 Methodology

This study employed a mixed-methods method that integrates qualitative and quantitative data. Secondary data, primarily the 2022 Uganda Demographic and Health Survey (UDHS), informed the identification of trends and patterns. Key informant interviews (KIIs) of policymakers, legal professionals, and healthcare workers and focus group discussions (FGDs) with reproductive-age women provided primary data. Data was collected ethically, i.e., informed consent, confidentiality, and cultural sensitivity, upon getting the university's approval as well as the concerned authorities.

Legal experts, government officials, health professionals, and women aged 15–49 years comprised the population under study. Quantitative data was processed in STATA version 18 using descriptive and inferential statistics like logistic regression to establish the association between predictors like income, education, and policy enforcement and maternal mortality. Qualitative data gathered from interviews and FGDs were processed using thematic analysis, and legal documents using content analysis. Pre-testing instruments, source triangulation of the data source, and careful cleansing of data were steps taken to ensure data quality. The study acknowledges sources of limitation including potential respondent bias and rendering it challenging to interpret legal enforcement in the context of meagre judicial precedents.

²⁴ MoH. (2022, August 1). *Sexual and Reproductive Health | MOH Knowledge Management Portal*. Url: <https://rb.gy/xgcm75> accessed 7th May 2025

However, the study offers valuable insights into systemic, legal, and social sources influencing maternal mortality in Uganda.

1.10 Outline of chapters

The study consists of four chapters. The introduction to the study is covered by Chapter One with the presentation of the background, problem statement, objectives, research questions, significance, justification, and study scope, among others, including an in-depth literature review as well as methodology adopted. Chapter Two explores the non-legal and legal aspects of maternal mortality in Uganda, including reproductive health regulations, human rights and feminist legal thought, international treaties, and domestic legislation governing the topic like the Constitution and the Public Health Act. Chapter Three offers quantitative and qualitative accounts for the collected data, *visa vi* the legal regime, the impact of socioeconomic determinants, and efficacy of healthcare policies against maternal death. Chapter Four concludes the book with a recitation of seminal findings, the conclusions based on the analysis, and real and policy implications, including recommendation arenas for additional studies. Supporting documents such as interview schedules and references are located in the appendices.

CHAPTER TWO

THE NON LEGAL ASPECT OF MATERNAL MORTALITY IN UGANDA.

Economic constraints are among the leading causes of maternal death in Uganda. The majority of women, particularly rural women, cannot afford to access health facilities, purchase necessary drugs, or pay for delivery and postnatal care. Access cost of maternal care remains a critical problem for the poor, which results in delayed seeking of care or avoidance of health facilities, thus the risk of maternal deaths from preventable causes (Dahab & Sakellariou, 2020). Even when government services are technically free, there remain informal payments and out-of-pocket expenditure, which disadvantage the poor (UBOS, 2023).

The economic status of women is also directly related to their level of education as well as whether they have access to employment in formal sector, both of which influence the outcome of maternal health²⁵. Better educated and more financially secure women are most likely to engage in antenatal visits, deliver in a facility and receive emergency obstetric care when it is needed (Dantas and others 2020)²⁶. However, the majority of women residing in Uganda's rural and pre-urban regions are either not employed or, if they are employed, work in the informal economy with unstable income, limiting their autonomy and ability to make imperative healthcare choices (Chen and others 2016; UBOS, 2023).

Social cultural factors where by the social traditions and beliefs of delivery being carried out by traditional birth attendants commonly known as “mulerwa” is health-seeking who lack the scientific knowledge in regards to life changes of an expectant mother because to most Ugandan women, pregnancy and delivery are seen to be natural occurrences in the majority of societies and hence do not require hospitalization, leading to the utilization of traditional birth attendants (TBAs), yet they lack the training and facilities required to manage complications²⁷.

One more significant socio-cultural barrier is gender inequality, which limits women's autonomy to make healthcare choices. In patriarchal societies like most in Uganda, men usually have control over household resources as well as decision-making, even in accessing maternal

²⁵ Amwonya, D., Kigosa, N., & Kizza, J. (2022). *Female education and maternal health care utilization: evidence from Uganda. Reproductive Health, 19(1)*. <https://doi.org/10.1186/s12978-022-01432-8> accessed 13th April 2025

²⁶ *Supra*

²⁷ *Supra*

health care. This translates to delay or denial of care when complications arise²⁸. Additionally, household activities and cultural expectations typically place women in positions where their health is not being maintained, thereby placing them at maternal risk (Adatara and others, 2019)²⁹.

A similar fear of stigma and mistreatment in the health facilities also discourages women from accessing professional maternal care like hospital deliveries (Teshale and others. 2025). Abuse, neglect, and discrimination by medical practitioners have been documented especially among unmarried women, young women or those of low socioeconomic status³⁰. These poor experiences erode trust in the healthcare system and encourage the use of home deliveries or traditional care. Community outreach and sensitization, health worker reform and accountability, and training are needed to transcend these socio-cultural impediments³¹.

2.3 Quantitative Analysis on Socioeconomic Factors Affecting Maternal Mortality

Table 2: Logistic Regression Results

Died due to pregnancy complications		Odds Ratio	St.Err.	t-value	p-value	[95% Conf. Interval]		Significance
Highest Education Level	no education	5.511	1.202	7.83	0.00	3.594	8.449	**
	Primary	5.006	1.059	7.62	0.00	3.308	7.577	**
	Secondary	2.996	.646	5.08	0.00	1.963	4.572	**
	Base: Higher	1	.	.	.	.	.	*
Type of place of residence	Urban	.992	.078	-	0.92	.851	1.158	
	base: Rural	1	.	.	.	.	.

²⁸Muheirwe, F., & Nuhu, S. (2019). Men's participation in maternal and child health care in Western Uganda: perspectives from the community. *BMC Public Health*, 19(1). <https://doi.org/10.1186/s12889-019-7371-3> accessed 9th May 2025

²⁹ Supra

³⁰ Oluoch-Aridi, J., Smith-Oka, V., Milan, E., & Dowd, R. (2018). Exploring mistreatment of women during childbirth in a peri-urban setting in Kenya: experiences and perceptions of women and healthcare providers. *Reproductive Health*, 15(1). <https://doi.org/10.1186/s12978-018-0643-z> (20th April 2025)

³¹Teshale, M. Y., Bante, A., Belete, A. G., Crutzen, R., Spigt, M., & Stutterheim, S. E. (2025). Barriers and facilitators to maternal healthcare in East Africa: a systematic review and qualitative synthesis of perspectives from women, their families, healthcare providers, and key stakeholders. *BMC Pregnancy and Childbirth*, 25(1). <https://doi.org/10.1186/s12884-025-07225-8> accessed 10th April 2025

Wealth index	Poorest	1.575	.169	4.22	0.00	1.275	1.945	**
					0			*
	Poorer	1.46	.159	3.48	0.00	1.18	1.807	**
					1			*
	Middle	1.252	.137	2.06	0.04	1.011	1.551	**
				0				
	Richer	1.331	.143	2.66	0.00	1.078	1.644	**
					8			*
	Base: Richest	1	.	.	.	.	.
Marriage type	Civil	1.462	.487	1.14	0.25	.762	2.807	
					3			
	Base: Customary	1	.	.	.	.	.
	Religious	1.047	.091	0.53	0.59	.883	1.241	
				9				
	Not officially married	1.158	.06	2.83	0.00	1.046	1.281	**
					5			*
Age group	Base: 15-19	1	.	.	.	.	.
	20-24	1.552	.262	2.60	0.00	1.115	2.16	**
					9			*
	25-29	3.073	.507	6.80	0.00	2.223	4.247	**
					0			*
	30-34	5.071	.834	9.88	0.00	3.674	7	**
					0			*
	35-39	7.732	1.285	12.3	0.00	5.583	10.708	**
			1	0			*	
40-44	13.167	2.27	14.9	0.00	9.392	18.458	**	
			5	0			*	
45-49	13.601	2.8	12.6	0.00	9.086	20.36	**	
			8	0			*	
No. of hospital visits during pregnancy	: base	1	.	.	.	.	.
	Never visited							
	1-9 visits	.596	.107	-	0.00	.419	.848	**
			2.87	4			*	
	More than 9	.829	.151	-	0.30	.581	1.183	
				1.03	2			
Constant		.01	.003	-	0.00	.005	.018	**
				14.4	0			*
				4				

The logistic regression results show that education level has a strong and statistically significant effect on the likelihood of maternal death due to pregnancy complications. Women with no education were over 5.5 times more likely to die from pregnancy complications compared to those with higher education, and even those with primary and secondary education had significantly higher odds (5.006 and 2.996 respectively), all with p -values < 0.001 . This highlights that education empowers women to access, understand, and utilize maternal health services effectively, reducing their risk of mortality. Education also often correlates with improved health-seeking behaviour and decision-making power during pregnancy.

Wealth index also showed a significant gradient effect on maternal mortality. Compared to the richest women (reference group), those in the poorest wealth category were 1.575 times more likely to die, with consistent trends for poorer, middle, and richer groups—all statistically significant. This suggests that socioeconomic deprivation increases the risk of maternal death, possibly due to poor access to skilled care, transport barriers, and inability to afford essential maternal health services. Interestingly, urban residence did not show a significant difference from rural, which may reflect that access barriers persist even in urban settings, or that quality of care in rural areas has improved.

Age and antenatal visits were also critical. Women aged 45–49 years had 13.6 times higher odds of maternal death compared to those aged 15–19, and risk increased progressively with age—indicating that older maternal age is a high-risk factor, likely due to increased physiological complications and co-morbidities. In addition, women who made 1–9 antenatal visits were 40% less likely to die compared to those who never visited a hospital (OR = 0.596, $p = 0.004$), showing that early and regular antenatal care is essential for reducing mortality. However, making more than 9 visits did not show a significant difference, which could indicate diminishing returns or selection bias where more visits are prompted by high-risk pregnancies. These findings call for targeted policies to improve education, address income inequality, and promote timely antenatal care to reduce maternal deaths.

2.4 Discussion of the key findings on Socioeconomic Factors in Maternal Mortality

The findings are consistent with an extremely high level of correlation between socioeconomic factors—education, wealth, and age—and maternal mortality in Uganda. The logistic regression reveals that uneducated women are 5.5 times more likely to die from pregnancy complications than better-educated women, and those with primary and secondary education

only still possess very high risks. The literature supports these findings by showing that education empowers women to gain health literacy, access to information, and timely healthcare decision-making ability Amwonya and others (2022)³² Education also increases the chances of having received antenatal care, and as this study found, women who received 1–9 antenatal visits were less likely to have died compared to women who did not receive any hospital visitation, confirming the safeguarding function of maternal health education.

Wealth was also a significant determinant and the poorer women had higher odds of maternal deaths. For example, the poorest wealth quintile had 1.57 times the odds of dying than the richest quintile. This is in agreement with previous literature that has noted resource limitations impeding the use of quality health care, emergency obstetric care, and prompt transportation (Chauke, 2024; Amosse and others 2021). The restricted health insurance coverage in this data (only 1.2%) also expands these disparities, a testament to an overbearing out-of-pocket cost that poor women cannot afford. Without universal health coverage or subsidies of maternal care, socioeconomic inequality maintains elevated maternal mortality.

Age is yet another factor, and maternal risk of mortality escalated significantly in older women. Those aged 40–44 years were 13 times more likely to die as a result of pregnancy complications compared to those 15–19 years, and the odds were even greater for those aged 45–49 years. Increased maternal age has been correlated with increased complication of hypertension and obstetric haemorrhage, requiring specialized treatment which may not reach all (Aregbeshola others 2020; WHO, 2019; Huang others, 2018). In conjunction with socioeconomic barriers like infrastructural challenges and infrastructural deficits presented in the report, older, poorer women bear a disproportionate impact. These results point to the vital need for evidence-based targeted interventions to respond to social inequalities and enhance access to quality, age-Ibid

³² Ibid

CHAPTER THREE

LEGAL FRAMEWORK GOVERNING MATERNAL MORTALITY HEALTH IN UGANDA.

3.1 Introduction.

This chapter discusses international, regional and domestic level legal frameworks governing maternity mortality.

3.2 International legal framework.

3.2.1 Human Rights Theory (Right to Life, Right to Health)

The Human rights theory underscores how maternal health becomes a human right grounded in the right to life and the right to health (WHO, 2023). According to the Universal Declaration of Human Rights (UDHR) article 25 and the International Covenant on Economic, Social, and Cultural Rights (ICESCR) article 12, everyone is entitled to what is possible in terms of attaining the highest standard of health, including maternal healthcare (UNHRC, 2022). Article 39 in the Constitution of Uganda gives the right to cleanliness and health further consisting of maternal healthcare services (Government of Uganda, 2023). Still, lack of access and appropriate services in health persists, bringing about preventable death of mothers and breach of these most primary rights (WHO, 2024). More courts are identifying maternity mortality as a breach of human rights as reflected in examples where courts find governments as guilty of inadequate service in maternal health care¹³. Consequently, ensuring that access to quality maternal health services is universal is a policy goal but also a legal and moral commitment under international human rights law.⁵

3.2.2 Feminist Legal Theory (Discrimination in maternal healthcare).

According to Feminist Legal Theory, various factors contributing towards maternal mortality are gender inequality and systemic discrimination, especially through lack of legal protections and policy failures (Mohapatra & Wiley, 2019; Figueroa and others³³. 2023; Kalindi and others.

³³ Mohapatra, S., & Wiley, L. F. (2019). *Feminist perspectives in health Law. The Journal of Law Medicine & Ethics*, 47(S4), 103–115. <https://doi.org/10.1177/1073110519898047> accessed on 19th march 2025

2023; MacKinnon, 2023)³⁴. Maternal health challenges emerge from structural injustices whereby the patriarchal nature of law and healthcare systems fails women in respect of their reproductive rights (Rajat & McLaren, 2023; Coen-Sanchez others. 2022; Shirazi, 2022). In Uganda, socio-cultural biases and economic constraints serve to disadvantage women in attaining maternal health services and limit their ability to make informed decisions regarding their health (Namasivayam and others, 2022; Potasse, 2020)³⁵. Legal impediments to reproductive rights, including Uganda's harsh abortion laws, aggravate the risk of maternal mortality by forcing women to seek unsafe alternatives (Apio, 2023). The theory demands that legal reforms develop mechanisms that empower women, abolish any policy discriminatory towards women and treat reproductive health as a fundamental element of gender equality (UN Women, 2024). A feminist legal approach to maternal mortality guarantees that laws and policies were structured to consider the specific needs and rights of women³⁶.

3.2.3 Convention on the Elimination of All Forms of Discrimination against Women.

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which was adopted by the UN General Assembly in 1979 is one of the main instruments related to women's reproductive rights, including maternal health. Article 12 of the CEDAW further requires states parties to ensure there are proper measures to eliminate discrimination against women in healthcare schemes and malpractices and make adequate maternal health services available (United Nations, 2020). The Committee on CEDAW has consistently asserted that states cannot ignore maternal mortality as a human rights concern and urged states such as Uganda to eliminate the legal, economic, and cultural hurdles through which women pass in accessing maternal care of quality. Problematic elements such as weak enforcement mechanisms and insufficient funding continue to stand in the way of its full implementation in Uganda even after it had ratified CEDAW (Avigad et al., 2024). Denial of minimum maternal health services, especially in rural areas, constitutes a violation of Uganda's CEDAW

³⁴ Kalindi, A. M., Houle, B., Smyth, B. M., & Chisumpa, V. H. (2023). *Gender inequities in women's access to maternal health care utilisation in Zambia: a qualitative analysis*. *BMC Pregnancy and Childbirth*, 23(1). <https://doi.org/10.1186/s12884-023-06078-3> accessed on 8th march 2025

³⁵ Potasse, M. (2020, October 6). *Understanding Perceived access barriers to contraception through an African feminist lens: A Qualitative study in Luweero, Uganda*. On <https://ruor.uottawa.ca/handle/10393/41188> accessed 25th march 2025

³⁶ Wardhani, L. T. a. L., & Natalis, A. (2024). *Assessing state commitment to gender equality: A feminist legal perspective on legislative processes in Indonesia and beyond*. *Multidisciplinary Reviews*, 7(6), 2024120. <https://doi.org/10.31893/multirev.2024120> accessed on 5th May 2025

obligations, as emphasized in recent UN reports (UNFPA, 2023). Furthermore, Uganda's restrictive abortion laws have faced criticism for being inconsistent with CEDAW's provisions regarding reproductive rights and a woman's autonomy over her health (Pizzarossa et al., 2023).

3.2.4 International Covenant on Economic, Social, and Cultural Rights.

The 1966 ICESCR acknowledges the right to health as a fundamental human right, requiring states to reduce maternal mortality and improve maternal health measures³⁷. The Committee on Economic, Social and Cultural Rights (CESCR) has specified this obligation, saying that preventable maternal deaths are a violation of the right to health (WHO, 2023). Uganda as a state party to the ICESCR has the obligation to ensure the availability, accessibility, acceptability and quality of maternal healthcare services in the country, but the practicalities of this are hindered by inequalities in healthcare access as well as funding constraints (Kiracho-Ekirapa and others, 2023). The health budget allocation for the country is below the set 15% target by the Abuja Declaration, affecting maternal health service delivery (UNICEF, 2023). Also, contributory structural barriers such as high healthcare cost and inadequate legal measures for maternal health and possible gender discrimination have continued to undermine Uganda's fulfilment of ICESCR commitments (UNFPA, 2024). The soaring maternal mortality rates continue to mostly affect the disadvantaged and poor communities, indicating violations in Uganda's compliance with its ICESCR obligations (Birabwa and others, 2024)³⁸.

3.2.5 Sustainable Development Goals (SDG 3 – Good Health and Well-being)

As per the Sustainable Development Goals (SDGs) adopted in 2015, an internationally drawn goal set in the year 2015, five years ago, specifically SDG 3.1, has the more ambitious target of reducing the global maternal mortality ratio to less than 70 per 100,000 live births by 2030 (WHO, 2024). Uganda's maternal mortality rate, as reported in the 2022 Uganda Demographic and Health Survey (UBOS, 2023), stands at 189 per 100,000 live births. This is still far beyond the target and, thus, calls for more stringent rounding-the-corner policy and legal interventions. Of course, SDG 3 is featured in the National Development Plan III and the Health Sector Development Plan of Uganda but limited resources and infrastructure continue to negatively affect progress (NPA, 2020). Apparently, just 60% of all births in Uganda are attended by a skilled healthcare professional, far below what is set for universal safe maternal care (UNICEF,

³⁷WHO. (n.d.). *The right to health*.

<https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf> accessed on 4th April 2025

³⁸ *Supra*

2024). Gaps in law and policy such as restrictive reproductive health laws and the weak enforcement of maternal health rights pose huge obstacles to the attainment of SDG 3 (Perehudoff and others 2022). According to the world health organization (2024), it calls for increased investment in maternal health with stronger legal frameworks to align the Ugandan maternal health care system with the SDG 3 objectives. There are no big reforms in terms of legality and policy; thus, Uganda may not fulfil its SDG commitments, further exacerbating the maternal mortality challenges within the country.

3.3 Regional legal framework.

The East African Community Treaty article 118 promotes and protects Human Rights, including those related to maternity Health care which promotes the rights of women and to realise this, an instrument was developed called the integrated East African Community Reproductive, Maternal, New-born, Child and adolescent Health (RMNCAH) Strategic Plan (2016-2021) focuses on harmonization and integration, reproductive, maternal, new-born, child and adolescent health services by eliminating preventable deaths of maternal and child under-five deaths in the East Africa and Partner states by 2030 in line with Sustainable Development Goals and the Global strategy for women's, children's and adolescent's health.

3.4 Domestic legal framework.

3.4.1 Constitution of Uganda.

The Constitution³⁹ guarantees a clean and healthy environment for all Ugandans to mean access to quality healthcare services such as those pertaining to maternal health (Government of Uganda, 2023). The Constitution⁴⁰ still provide that the state has to make either make sure that there are medical services to the citizens and access to adequate clean water respectively. Also stresses the state's responsibility to protect the rights of women⁴¹, especially in matters concerning pregnancy and childbirth, by ensuring that policies promote maternal health as it states that no person has a right to terminate life⁴² and this emphasised in the case of CEHURD and Joyce Nakachwa V Attorney General and Kampala City Council⁴³. In spite of constitutional provisions, Uganda has been recording higher rates of maternal mortality owing to poor health infrastructure and limited access to maternal health services, especially

³⁹ *The Constitution of The Republic of Uganda 1995 (Amended) Art 39*

⁴⁰ *Constitution of The Republic of Uganda, national objectives XX and XXI*

⁴¹ *Ibid Art 33*

⁴² *Ibid Art 22 (2)*

⁴³ *Constitutional Petition 2 of 2001*

in the rural part⁹. It has been held by courts such as in *CEHURD & Others v. Attorney General*⁴⁴, also in the case of *CEHURD and others V Nakaseke District Local Administration*⁴⁵ that the state must give preferential consideration to maternal health care and that any laws permitting preventable maternal deaths are unconstitutional (Haki, 2023). However, these provisions have weak enforcement mechanisms due to lack of legal pursuing and budgeting (Mukuru and others 2021). Therefore, maternal mortality still finds itself pressing, notwithstanding Uganda's constitutional pledge to the right to health care (Magunda and others 2023).

3.4.2 Public Health Act and National Health Policy.

The Public Health Act⁴⁶, which came into force in 1935 as amended provides a framework for public health legislation, including maternal health services in Uganda (Government of Uganda, 2021). The Act has been criticized for being outdated and failing to put down clear provisions in support of maternal health rights and duties⁴⁷. The NHP set up in 1999 and revised in 2010 to strengthen the healthcare system in Uganda through a focus on maternal and child health services (MOH, 2022), calls for universal access to maternal health services; however, implementation is hampered by low funding, inadequate workforces, and weak infrastructure⁴⁸. Some commentators say that Uganda's failure to achieve its national targets on maternal health Sustainable Development Goal (SDG 3.1)⁴⁹ is a direct consequence of the inability to fully implement the National Health Policy (UNFPA, 2024). Furthermore, the public healthcare system's maternal health services remain poorly funded, with just 9.2% of the national budget being allocated to health, way below the prescribed 15% in the Abuja Declaration (UNICEF, 2023). Weak implementation of the Public Health Act and underfunding of the National Health Policy have presented a dual challenge, which has been

⁴⁴ *Ibid* No. 16

⁴⁵ *HC Civil suit No.111 of 2012*

⁴⁶ *Cap 281 (1935)*

⁴⁷ *supra*

⁴⁸ Sarikhani, Y., Najibi, S. M., & Razavi, Z. (2024). *Key barriers to the provision and utilization of maternal health services in low-and lower-middle-income countries; a scoping review*. *BMC Women S Health*, 24(1). <https://doi.org/10.1186/s12905-024-03177-x> retrivied on 10th May 2025

⁴⁹WHO. (2024). *SDG Target 3.1 maternal mortality*. World Health Organization. Retrieved March 8, 2025,

from <https://www.who.int/data/gho/data/themes/topics/sdg-target-3-1-maternal-mortality> accessed on 16th April2025

crucial in sustaining the still-high maternal mortality crisis in Uganda (Mukuru and others, 2021)⁵⁰.

3.4.3 The allied Health Professionals Council Act Cap.268

This establishes The Allied Professionals Council which regulates, supervises and controls the training and practice of The Allied Health Professionals in Uganda. The council protects the public by maintaining up to date registers of registered and licensed professionals, private Health Units and recognised training institutions which are published in the Uganda Gazette every year.

3.4.4 The Medical and Dental Practitioners Act.

It establishes The Medical and Dental Practitioners Council⁵¹ which monitors and exercises general supervision and control over and maintenance of professional medical and dental standards, enforcement of medical and dental ethics. Part V of this Act approves the eligibility and recognition of qualification⁵² for each speciality in the medical practice which protects the public from ending up in the hands of unqualified medical persons

3.4.5 Reproductive Health Guidelines and Judicial Precedents on Maternal Health.

The guidelines for reproductive health in Uganda developed by the Ministry of Health are a policy framework for improving maternal health services, for instance, family planning, emergency obstetric care, and postnatal care (MoH, 2022). However, enforcement of these guidelines is weak, especially in rural areas where health care infrastructure is low (WHO, 2024). The case of CEHURD and Nakayima Florence versus Attorney General and Mulago Referral Hospital⁵³ demonstrated the inadequacy of Uganda in delivering essential maternal health services which further strengthens the legal responsibility of the government to provide for preventable maternal death (Haki, 2023)⁵⁴. The ruling emphasized that a state's failure to provide timely and quality maternal healthcare services contradicts basic rights under Uganda's constitution and international legal commitments. Unsafe abortion constitutes a substantial

⁵⁰ *Supra*

⁵¹ *The medical and Dental Practitioners Cap 272 of 1998*

⁵² *Ibid Section 17 and 18*

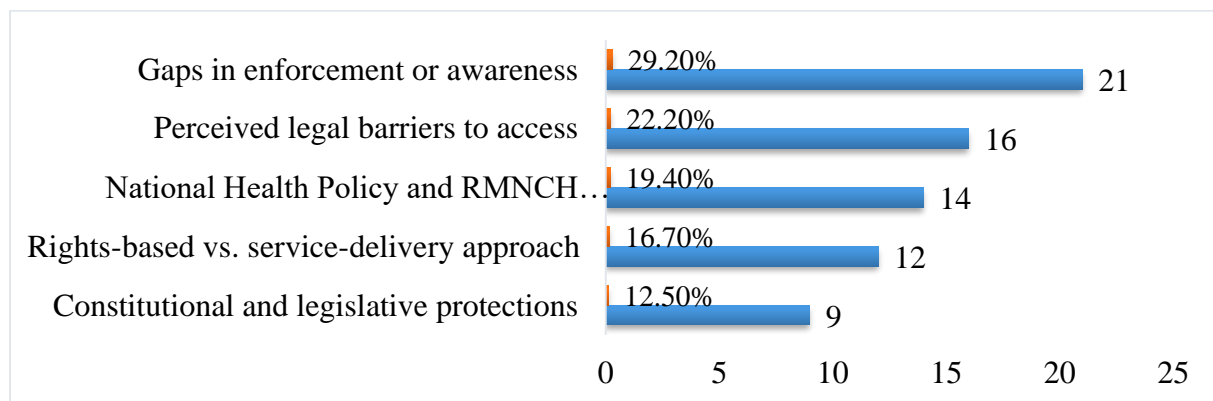
⁵³ *HC civil suit no.327 of 2020*

proportion of m⁵⁵aternal deaths, with restrictive abortion laws in Uganda adding to the causes of maternal mortality⁵⁶.

3.4.4 Qualitative Analysis Legal Framework Governing Maternal Health in Uganda.

This section presents a qualitative analysis of Uganda’s legal framework governing maternal health, based on primary data collected through Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs). The data was gathered from a diverse group of participants, including health workers, housewives, legal officers, local leaders, and policymakers, to ensure a broad representation of perspectives and lived experiences. Semi-structured questions and guide discussions. The insights generated helped identify key themes and gaps in legal enforcement, awareness, and the overall rights-based approach to maternal healthcare in Uganda.

Figure 9: Effectiveness of Legal Framework Governing Maternal Health in Uganda



Gaps in Enforcement or Awareness was the most cited issue by 29.2% of the respondents highlighting major gaps in enforcement of existing laws and widespread lack of awareness among both service providers and users. Respondents expressed frustration that while Uganda has policies and laws supporting maternal health, the systems for monitoring and enforcing them are weak or non-existent.

In an interview with a district-level health officer, he stated, “*You can have the best policy in the world, but if the midwives don’t even know it exists, how can they follow it? There’s no training, no follow-up, no consequences.*” This means that maternal health laws and policies are rendered ineffective due to inadequate dissemination, lack of training, poor supervision, and limited accountability mechanisms. As a result, maternal health services are inconsistently

⁵⁵ *Supra*

provided, and rights violations go unaddressed, contributing to continued high maternal mortality rates.

Perceived Legal Barriers Health services accessibility was also another challenge cited by 22.2% of the surveyed respondents, showing that a substantial number of participants identified systemic and structural legal issues as barriers to accessing maternal care. These included discriminatory practices, cumbersome consent requirements, or limited access to legal recourse for mistreatment.

In an interview with a rural health centre in-charge, she said, *“Sometimes husbands must approve before a woman can get care. If she’s under 18, she’s practically helpless if the parents aren’t around. The law isn’t clear, and health workers fear being sued.”* This means that unclear legal guidelines, gender norms, and fear of legal consequences contribute to delays and denials of care. These barriers make maternal services inaccessible, particularly for young or unaccompanied women, thus increasing the risk of complications and maternal deaths.

National Health Policy and RMNCH Strategy was cited 14 times (19.4%), reflecting stakeholder recognition of Uganda’s National Health Policy and its Reproductive, Maternal, New-born, and Child Health (RMNCH) strategy. While these policies exist and are frequently referenced in planning documents, concerns were raised about their operationalization and impact at the grassroots level.

In an interview with a Health NGO Representative, he said, *“We have policies on paper, yes, but they don’t reach the communities. Most health workers don’t even know what the maternal health law says, and the local women definitely don’t.”* This means that the disconnect between policy formulation and implementation significantly limits the success of maternal health programs. Despite having robust policies, the lack of awareness, training, and community involvement in policy implementation hinders their effectiveness in reducing maternal mortality.

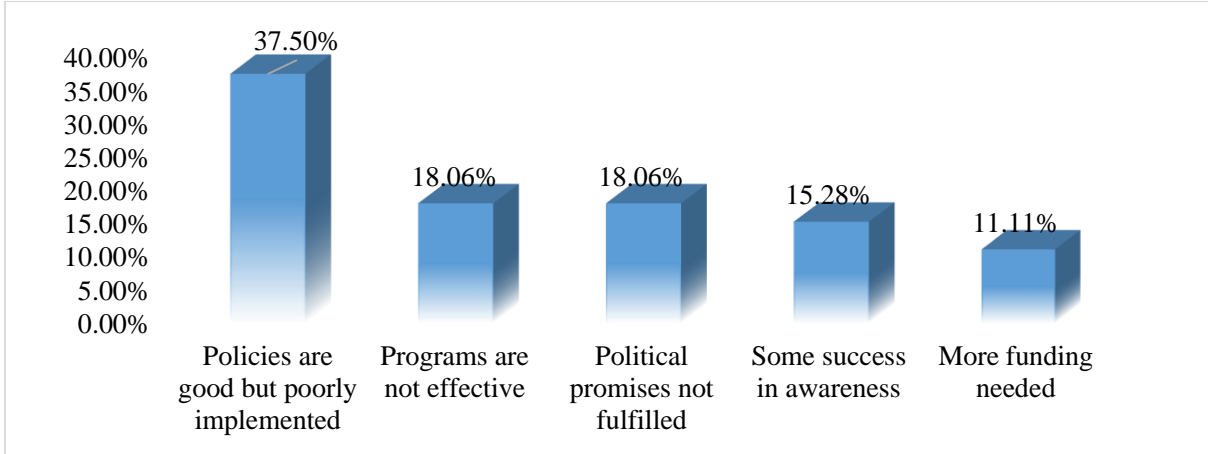
About 16.7% addressed the conflict between rights-based approaches and traditional service delivery models. Respondents expressed concern that maternal health interventions in Uganda are more focused on service provision (e.g., clinics, equipment, staff) than on empowering women to claim maternal health as a legal right.

In an interview with a gender activist from a women’s rights NGO, she noted, “*Maternal health here is treated like charity work. We don’t see it as a woman’s right. It’s like we’re asking for favours from the system.*” This means that maternal health is not fully integrated into a rights-based framework where accountability and legal entitlement are central. Instead, health services are delivered in a top-down, often inconsistent manner, which weakens the long-term sustainability and empowerment effects of health interventions.

Constitutional and Legislative Protections issue received the least attention among respondents, with 12.5% pointing to this as a key cause of maternal mortality. This may reflect limited public awareness or accessibility of Uganda’s constitutional and legal safeguards related to maternal health. While the Constitution guarantees the right to health and other supportive legal frameworks exist, they are often not directly referenced in day-to-day health service delivery or advocacy work.

In an interview with a legal aid officer, he said, “*There are constitutional rights, yes, but how many women in the villages even know these exist? They’re not empowered to claim these rights, and the health system rarely invokes them.*” This means that while the legal provisions are in place, their practical use is limited due to low awareness, limited legal literacy among women, and the absence of rights-based implementation in health institutions. The gap between constitutional law and local-level enforcement leaves many maternal health rights unrealized.

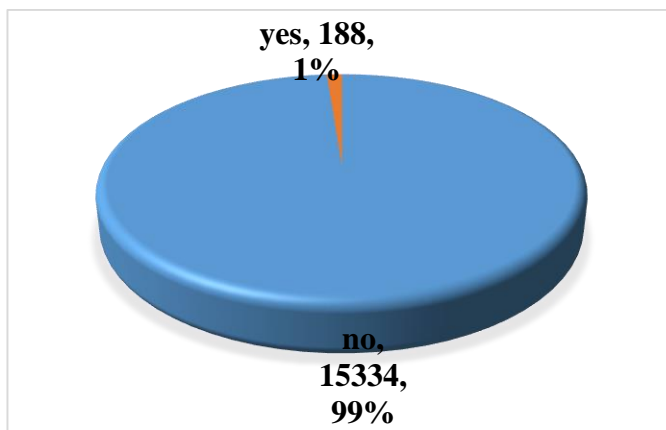
3.4.5 Analysis of Effectiveness of Uganda’s Healthcare Policies.



While some policies exist, 37.50% of respondents believe they are good but poorly implemented, suggesting a gap between policy formulation and practical execution. Also, 18.06% report that programs are not effective, and another 18.06% cite unfulfilled political promises, highlighting systemic weaknesses in governance and accountability. Only 15.28%

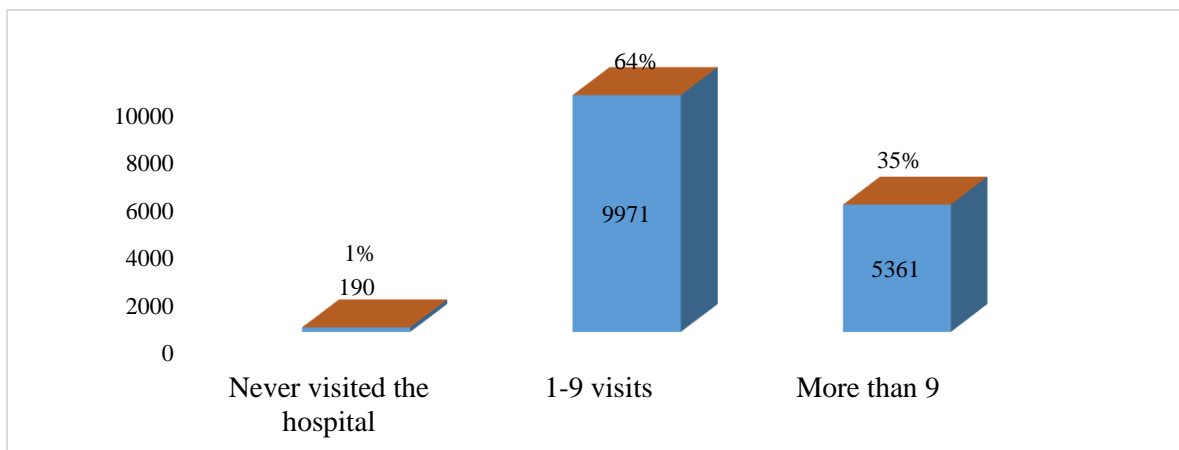
acknowledge some success in awareness creation, indicating minimal but notable progress in public health education. 11% stress the need for increased funding, pointing to resource constraints as a key barrier. These findings collectively underscore that although Uganda has maternal health policies in place, their impact is undermined by weak implementation, inadequate political commitment, and insufficient investment, necessitating urgent reforms in policy execution, monitoring, and resourcing to reduce maternal mortality effectively.

Figure 10: Insurance coverage



Only 1% of the women are covered by health insurance, while an overwhelming 99% reported having no health insurance at all. This stark disparity highlights a critical gap in financial risk protection for healthcare, especially maternal health.

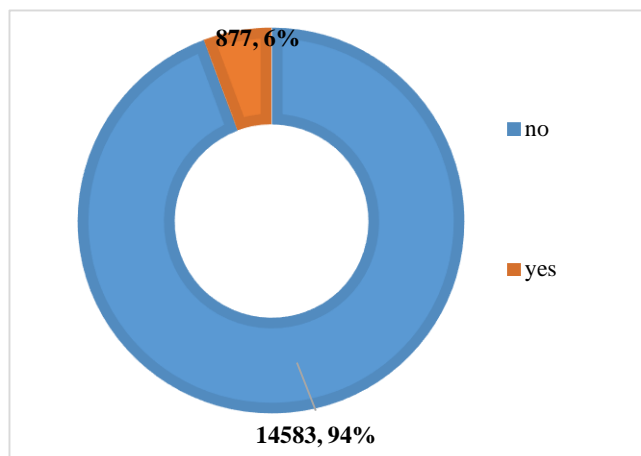
Figure 11: Frequency of hospital visit during pregnancy



A substantial proportion of respondents, 64%, made between 1 to 9 visits during their pregnancies, which is the most common pattern observed. A smaller but still significant group, 35%, had more than nine antenatal visits, suggesting that some women are proactive in seeking comprehensive maternal care. However, 1% reported never visiting the hospital, which is

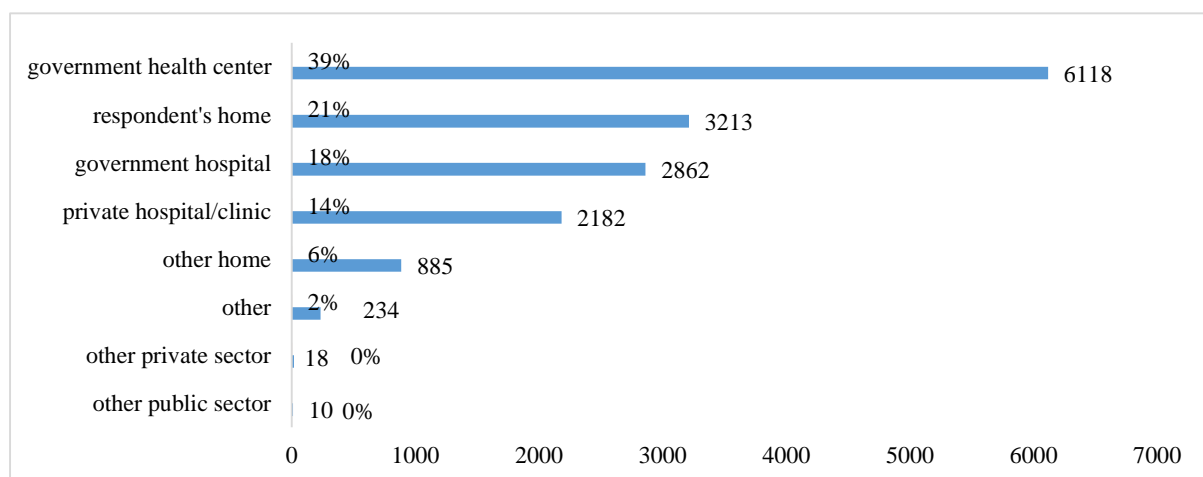
concerning as it indicates a lack of access or awareness, possibly due to socio-economic barriers, cultural factors, or healthcare infrastructure limitations. The high percentage of women attending at least one antenatal visit (99%) is promising, yet the low attendance in more frequent visits indicates potential issues with sustained maternal care access, particularly for high-risk pregnancies. This trend calls for improvements in healthcare accessibility and community-based interventions to encourage consistent antenatal care, which is crucial for reducing maternal mortality.

Figure 12: Delivery by caesarean section



The majority of births, 94.33% are not by a caesarean section. This low percentage may be due to challenges in access to skilled healthcare professionals, facilities, or adequate healthcare in certain regions. Underreporting of complications or insufficient availability of surgical services may also contribute to this issue.

Figure 13: Facility-based delivery

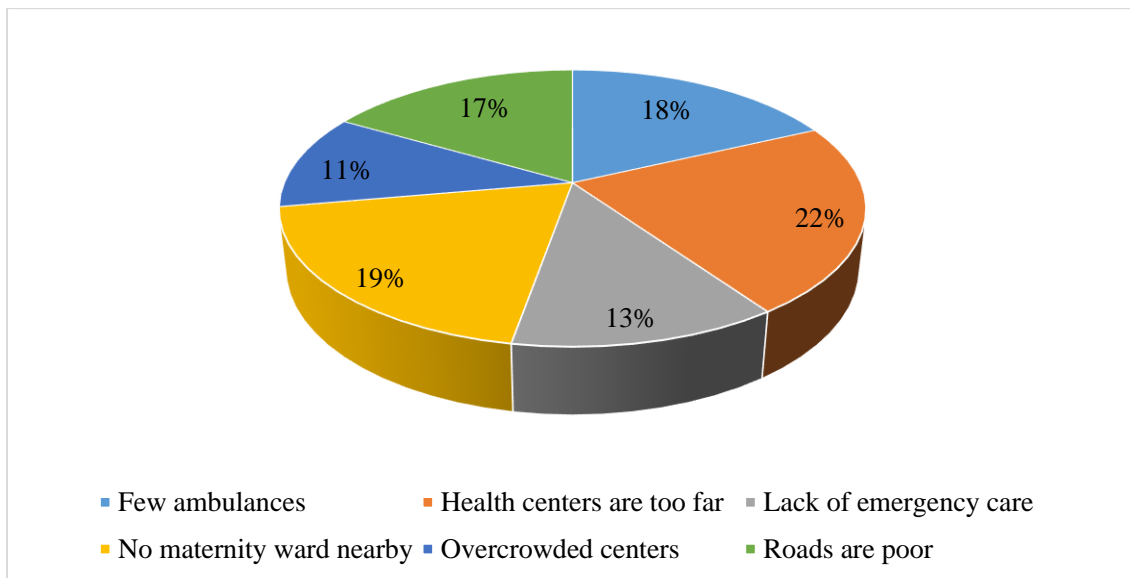


A significant portion of women gave birth in government health centers, accounting for 39% (6,118 respondents). This is followed by deliveries at respondent's home at 21% and government hospitals at 18.44%. On the other hand, private hospitals/clinics were the place of

delivery for 14%, reflecting some level of reliance on private healthcare services, which may be more accessible or offer perceived higher quality care for certain individuals. A small proportion of deliveries occurred at other homes (6%) and in other private sector facilities (0.12%). The relatively lower use of private sector services might be attributed to financial constraints or limited access in rural areas.

The presence of deliveries at respondent's homes (20.70%) also suggests cultural or logistical factors where women might prefer home births, possibly due to lack of access to facilities, distance, or personal preference. Furthermore, the minimal use of other public or private sector facilities points to gaps in healthcare access, especially in areas outside urban centres

Figure 14: Barriers to access (distance, cost, permission, transport)

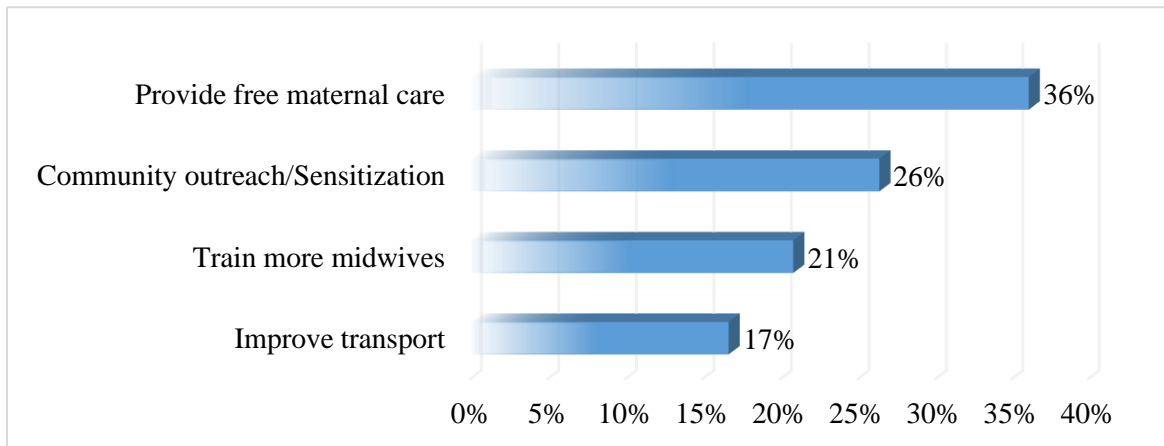


The most reported challenge was that health centers are too far, accounting for 22%, which is a common issue in many rural areas of Uganda. Long distances to health facilities can delay care, particularly for pregnant women in need of urgent attention, leading to adverse maternal outcomes. Similarly, the lack of maternity wards nearby (19%) and few ambulances (18%) reflect the insufficient investment in maternal health infrastructure and emergency transport systems, making it difficult for women to access timely and appropriate care.

In addition, poor road conditions (17%) and overcrowded health centers (11%) further compound access challenges. Poor roads not only delay transport but can also discourage women from seeking facility-based delivery services, especially during emergencies or at night. Overcrowding, on the other hand, signifies a shortage of both space and human

resources, which reduces the quality and timeliness of services provided. The lack of emergency care (13%) shows gaps in the referral system and emergency obstetric care, which are critical to reducing maternal deaths.

Figure 15: Recommendations for improvement



The largest proportion (36%) of respondents emphasized the need to provide free maternal care, suggesting that cost remains a significant barrier to accessing life-saving services. Community outreach and sensitization (26%) also ranked high, indicating the importance of increasing awareness about maternal health services, especially in rural and underserved areas. Training more midwives (21%) was another strong recommendation, highlighting the persistent shortage of skilled birth attendants, which contributes to high maternal mortality. Lastly, 17% suggested improving transport infrastructure, pointing to access challenges—especially for women in remote areas who struggle to reach health facilities in time.

3.4.6 Discussion of Key findings on Effectiveness of Uganda’s Healthcare Policies.

Uganda's policy and legal environment for maternal health care demonstrates intentions to improve maternal outcomes but does not follow through with actual implementation⁵⁷. The National Health Policy II (2010–2020), the Health Sector Development Plan (2015/16–2019/20), and the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality (2020–2025) highlight Uganda's focus on improving maternal health. Such policies encourage more skilled birth attendance, improved emergency obstetric care, and facility-based access to

⁵⁷ Wallace, L. J., & Kapiriri, L. (2019). Priority setting for maternal, ne WHO. (2023, February 23). Trends in maternal mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. World Health Organization. <https://www.who.int/publications/i/item/9789240068759> retrivied on 10th May 2025

antenatal care. But the study presented a revelation that 26.4% of women still give birth at home and a mere 5.67% of births are carried out by caesarean section, revealing poor accessibility and underuse of facilities. This is corroborated by Alemayehu and others (2024) observation, that despite policy commitment, capacity and staff required at most facilities remain lacking, especially in rural areas. Sarikhani and others (2024) also reason that quality weaknesses and geographical dispersal of maternal services continue to hamper the success of policies. Cybersecurity (2024) also indicates that effective weak frameworks of implementation as well as inadequacies of monitoring systems often thwart implementation of policies.

Financial access to maternal health care services is also a critical policy area where Uganda has failed. Although efforts at the set-up of the National Health Insurance Scheme (NHIS) have been on course, cover remains low, as seen in the research where only 1.21% of women were reported as covered. Payment is on an out-of-pocket basis, which acts as a disincentive to poor women for seeking timely services. This is supported by the findings of Mweemba and others. (2021), who noted the lack of ability on the part of poor households to access even the most minimum maternal health services. Findings by Magunda and others. (2023)⁵⁸ also prove that limited health financing in Uganda leads to inequality in service utilization and accessibility, particularly for rural and informal settlement women. Besides, Atuhaire and others (2023)⁵⁹ argue that if Uganda does not adopt universal health coverage and subsidized maternity care, then socioeconomic inequalities will continue to undermine the efficiency of health policies.

Structural and infrastructural limitations, such as lack of proximity to health facilities, poor roads, and availability of emergency care also limit the impact of maternal health policies. Long distances to health centres were quoted by 22% of respondents and a lack of ambulances by 18% in this research as among the key challenges. These findings accord with the work of Ustine (2023)⁶⁰, which revealed that many women in Uganda have delayed access to care due to transport challenges and road conditions. Similarly, Nabudere and others. (2013) also found that physical access issues and unavailability of maternity wards significantly reduce skilled birth attendance. Despite actions in the Health Sector Strategic and Investment Plan (HSSIP)

⁵⁸ *Supra*

⁵⁹ Atuhaire, P., Kiracho-Ekirapa, E., & Mutenyo, J. (2023b). *How equitable is utilization of maternal health services in Uganda? Implications for achieving universal health*

⁶⁰ Ustine, L. (2023, July 13). *Community access roads could unlock rural women's economic potential – Economic Policy Research Centre. Retrieved May 16, 2025, from https://eprcug.org/eprc-in-the-news/community-access-roads-could-unlock-rural-womens-economic-potential/accessed_on_30th_April_2025*

and the maternal health roadmap to respond to such challenges implementation has been slow due to stringent finances and weak accountability systems. Kaddu and others. (2023) put forward that for Uganda's policies to be even more effective, there must be targeted investments in infrastructure, logistics, and local health workforce development, along with rigorous policy implementation and citizen participation.

CHAPTER FOUR

4. SUMMARY OF FINDINGS, CONCLUSION, AND RECOMMENDATIONS.

4.1 Introduction.

The chapter summarizes results, presents conclusions, and gives recommendations with the aim of improving maternity health outcomes.

4.2 Summary of Key Findings.

4.2.1 Legal Framework Governing Maternal Health in Uganda.

The analysis of the legal environment regulating maternal health in Uganda reveals vast loopholes in law enforcement and the awareness of laws and policies. The survey showed that only 38% of the respondents said that government policies were good but not well implemented; 18% of the respondents were dissatisfied with the effectiveness of the programs. This implies that while there are wide-ranging policies such as the National Health Policy and the RMNCH Strategy, implementation at the grassroots level is a problem. The key informants, that is, policymakers and health workers noted that most of the health centers are not equipped, and the health workers are either not well trained or not well informed of maternal health law in some instances, thus affecting the quality of service delivery and the results on maternal health. As one health sector official remarked, "*We have policies in place, yes, but they don't make it to the communities.*"

Approximately 22% of respondents stated that significant legal barriers were in place to prevent the delivery of maternal health services. This is further exacerbated by enforcement gaps. Twenty-one percent of respondents reported that existing laws are not effectively monitored and enforced, which leads to widespread non-compliance. This, in turn, raises a major concern where legal protection on paper, such as free maternal care or rights-based approaches to health care, does not seem to have meaningful improvements on maternal health outcomes for women, especially in rural and underserved areas. Therefore, strong enforcement of laws and sensitization programs are needed to ensure that policies are implemented in service delivery and work, becoming an accessible option for pregnant women.

4.2.2 Role of Socioeconomic Factors in Maternal Mortality.

The socioeconomic factors results show that factors such as education, wealth, and age impact the probability of pregnancy-related complications with maternal death. The results indicate that the lower the level of education possessed by the woman, the greater the risk involved in

dying out of pregnancy complications. To be more precise, women with no education are assigned an odds ratio of 5.511. This means they are more than five times more likely to die from pregnancy complications than those women who have attained higher education. Women with a primary and secondary level of education also tend to face higher risks, albeit lower than those faced by women with no education, having odds ratios of 5.006 and 2.996, respectively. The results emphasize the importance of education in mitigating maternal death, possibly through educating the woman on how to seek adequate care and make satisfactory decisions during pregnancy.

Wealth is also a critical determinant in maternal health, with less economically endowed women at higher risks of maternal mortality. The logistic regression results show that the poorest wealth quintile women have an odds ratio of 1.575, or a significantly higher risk of maternal mortality than richer women. This trend is also present in other lower wealth groups, with "poorer," "middle," and "richer" category women also being at higher risk, albeit to a lesser extent. Age remains a significant predictor of maternal mortality, with older women being at very much increased risk. Women aged 40-44 and 45-49 years, for example, have odds ratios of 13.167 and 13.601, respectively, which reflect that maternal age is a critical factor resulting in pregnancy complications and maternal death. Such observations are indicative of the intersectionality of socioeconomic determinants wherein education, wealth, and age intersect to explain disparities in maternal health outcomes.

4.2.3 Effectiveness of Uganda's Healthcare Policies.

Most of the respondents, 38%, explained that though the policies are good, they are not properly implemented. This points to a gap between policy making and service provision, which could help to reduce the potential benefit of these policies to improve maternal health. Moreover, 18% of the respondents explained government programs do not work, which could be a pointer to inefficiency in the healthcare system due to lacking the necessary resources, poor infrastructure, or inadequate trained staff.

Political commitments to healthcare reforms are seen to still be underutilized with 18% of the participants identifying this as a key challenge. This perception reflects a gap between political commitments and realities on the ground, which may erode public trust in the health system. Some positive responses are there too because 15% of the participants identified some success in focusing maternal health issues into the spotlight. Despite this, the majority of the respondents (11%) emphasized that there is a need for more resources to improve healthcare

services, particularly in rural areas where access to health care remains a significant constraint. All this demonstrates the need for collective political will, adequate funding, and adequate communication towards improving delivery and efficiency of maternal health care policies in Uganda.

In conclusion Legal Framework Governing Maternal Health in Uganda, provides a solid foundation for the protection of women's rights and the safeguarding of access to high quality maternal health care. Yet, even with sufficient law and policy, its implementation is the greatest challenge. The findings of this study reveal loopholes in the implementation of these legislations, especially at the grassroots level, where women and health workers are not aware of their rights and available services. Poor resources and absence of coordination among stakeholders hinder proper provision of maternal health services. Thus, though there is the legal provision, the potential of such a legal system is not being exploited because there is poor enforcement, ignorance, and poor implementation strategies by the stakeholders.

The socioeconomic determinants of maternal mortality in Uganda are broad, but the major ones include education, economic status, and residence. It was found that women in the lowest educational group, especially those with either no education or just primary education, were at immensely higher risk of maternal death when compared to those in a higher educational category. Women in the lowest quintiles of wealth are also deprived of maternal life and pregnancy, further stating that economic disadvantage comes to mothers' health. Similar is the case for rural women: they encounter increased enemy travel time to health facilities, and they also lack adequate resources to buy good quality care. All these results indicate that the existence of socioeconomic disparities, poverty included, accounted for in adequate education and economic emancipation of women, is probably the core reason for maternal deaths in Uganda.

4.3.3 Effectiveness of Uganda's Healthcare Policies.

The effect of Uganda's health policies, most importantly maternal health policies continues to be constrained by numerous implementation challenges. Despite having highly developed policies such as the National Health Policy and RMNCH strategy, the research found that poor implementation and a lack of funding constrain them from being effective. A significant majority of the interviewees noted that despite policies, their implementation is typically weak, with political commitments to healthcare habitually not being fulfilled. Further, there is a dismal lack of emergency care facilities, inadequate infrastructure such as ambulances, and

crowded health centres, all which detract from the quality and accessibility of maternal healthcare. These findings demonstrate that while Uganda has a sound policy framework, more efforts on policy implementation, adequate financing, and development of infrastructure are needed to facilitate enhanced maternal health outcomes.

4.4 Recommendations.

In order to improve the returns of maternal health in Uganda, it is important to make stronger the legal as well as policy frameworks governing maternal health especially adopting Article 25 of the UDHR into the constitution of Uganda and declare right to health as non derogable right. The government must focus on ensuring proper implementation of existing policies at all levels. A review of policies should also focus on improving the emergency care, such as improved access to ambulances and improved referral systems for maternal emergencies. Moreover, the government needs to tackle incorporating maternal health policies across other sectors, including education and transport, to affect the overall socioeconomic determinants that influence maternal health to reduce all maternal deaths are preventable with good prenatal care and early medical treatment. Policymakers need to prioritize improving access to healthcare services, especially in poor and rural can be achieved by increasing the budget financing of the Health sector. Public-private partnerships by reduction of taxes and cost sharing in order to reduce on the high charges in private Health facilities. There should be a robust monitoring and evaluation system in place to track the implementation of mother's health policies, accountability and stringent measures on corruption and misuse of public funds allocated to the Health sector.

In practice, the improvement of mothers' health in Uganda requires concerted attention to healthcare provision services, particularly within the rural regions. One of the initial steps is to improve transport infrastructures, such as roads and also establishing community-based transport units, such as ambulances to facilitate accessibility health facilities by women within reasonable time when there is an emergency. More training of midwives and healthcare workers is also a key step which will address the shortages of skilled personnel and address the doctor-patient ratio deficiency currently at doctor 1 to 100 patients. Efforts must also be made to expand the maternal health outreach programs so that more awareness among women can be created on the significance of antenatal visits, proper nutrition, and signs in pregnancy that require emergency obstetric care for example pre-eclampsia. Also need for more health care facilities and expansion of the readily available one for proper response to overcrowding, which

is a primary barrier to quality care. The health centres must be well equipped with medical supplies, personnel, and facilities to handle the increasing maternal health cases that is breaking the monopoly of National Medical Stores as the only supplier to public Health facilities and equipping and training of community health workers are equally important for maternal health. Implementation of these practical measures at the grass root level will significantly improve maternal health outcomes and reduce the risk of maternal mortality.

There is a call for additional research to best determine the determinants of maternal mortality in Uganda, particularly the influence of socio-economic determinants. Future research would seek to explore the impacts of maternal health policy on diverse demographic groups, such as rural and urban communities, and establish the barriers to women's access to maternal health care services across regions of the country. Research on the effectiveness of targeted maternal health interventions, such as on high-risk pregnancies or emergency obstetric care, would be extremely valuable to determine how to make these interventions more effective. Longitudinal research on women's health and women's engagement with the health systems would also provide better insights into the problems in the system and suggest more targeted interventions.

Studies should explore the interplay between societal and cultural determinants and maternal health outcomes. Understanding the influence of cultural beliefs, social norms, and community views on the implementation of maternal care can inform policy and program interventions that are contextually responsive and culturally appropriate. Finally, there is a need for additional studies to identify the impact of health insurance on maternal health as the study showed poor coverage, particularly among low-income women and those residing in rural settings. Future studies would need to look at the barriers to insurance coverage and how expanding health insurance coverage can enhance maternal health services, particularly in poor-resource settings. These are areas that will be essential to guiding maternal health policy improvement and healthcare delivery system strengthening in Uganda.

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APPENDICES

Table 3: Appendix I(a): Work plan

Activity	Feb-2025	Mar-2025	Apr-2025
Proposal Development	4 weeks		
Proposal Submission & Approval		Week 3	
Development of Data Collection Tools		Week 4	
Ethical Approval & Clearance		Week 4	
Secondary Data Collection (UDHS, UBOS, Reports)		Week 4	
Primary Data Collection (KIIs, FGDs, Surveys)			Week 1
Data Entry & Cleaning			Week 2
Data Analysis & Interpretation			Week 3
Report Writing (Findings & Discussion)			Week 3
Final Report Compilation & Editing			Week 4
Submission of Final Report			Week 4

Table 4: Appendix I(b). Budget

Item	Quantity/Units	Unit Cost (UGX)	Total Cost (UGX)
Proposal Printing & Binding	3 Copies	10,000	30,000
Transport for Data Collection	10 Trips	50,000	500,000
Stationery (Pens, Notebooks, Printing Paper)	Lump Sum	100,000	100,000
Internet & Communication	3 Months	100,000	300,000
Ethical Approval Fees	Lump Sum	150,000	150,000
Key Informant Interviews (Refreshments & Logistics)	10 Sessions	50,000	500,000
Focus Group Discussions (Refreshments & Venue Hire)	5 Sessions	100,000	500,000
Data Analysis Software (STATA Subscription)	1 License	300,000	300,000
Report Printing & Binding	3 Copies	20,000	60,000
Miscellaneous & Contingencies	Lump Sum	200,000	200,000
Total Estimated Cost			2,640,000

Focus Group Discussion (FGD) Guide

Target Group: Women of reproductive age (15–49 years), community health workers, and local leaders

Section A: Demographic Information

1. Age: _____
2. Marital Status:
 - Single
 - Married
 - Divorced
 - Widowed
3. Education Level:
 - No formal education
 - Primary
 - Secondary
 - Tertiary
4. Occupation: _____

Section B: Socioeconomic Factors Affecting Maternal Health

5. What are the major challenges women in this community face in accessing maternal healthcare?
6. How does household income affect access to maternal health services?
7. Are there any cultural beliefs or practices that influence maternal healthcare-seeking behavior?
8. How does a woman's level of education impact her decision to seek maternal health services?
9. In your opinion, what role do men play in maternal health decisions?

Section C: Healthcare System and Policy Challenges

10. What are the biggest challenges in accessing healthcare facilities for maternal health services?

11. Are maternal health services affordable and accessible in your area?
12. How would you rate the availability of trained healthcare providers in maternal health services?
13. Do you think government programs and policies on maternal health are effective? Why or why not?
14. What improvements would you recommend for maternal healthcare services in Uganda?

Section D: Legal Framework & Rights Awareness

15. Are you aware of any laws or policies that protect maternal health rights in Uganda?
16. Have you or someone you know experienced discrimination or mistreatment during childbirth?
17. What do you think the government should do to improve maternal health and reduce mortality rates?

Thank you for your participation

Key Informant Interview (KII) Guide

Target Group: Health officials, policymakers, legal experts, and NGO representatives

Section A: Background Information

1. Name (Optional): _____
2. Organization/Institution: _____
3. Designation: _____
4. Years of Experience in Maternal Health: _____

Section B: Legal & Policy Framework

5. What are the key legal provisions governing maternal health in Uganda?
6. How effective is the enforcement of these laws and policies?
7. What are the major legal barriers to maternal healthcare access in Uganda?
8. Are there any landmark cases or judicial precedents that have influenced maternal health policies?

Section C: Healthcare System & Policy Implementation

9. What are the major challenges facing Uganda's healthcare system in addressing maternal mortality?
10. How would you assess the government's commitment to maternal health?
11. How has Uganda progressed in implementing SDG 3 (Good Health and Well-being) concerning maternal health?
12. Are there any gaps in Uganda's maternal health policies that need urgent attention?

Section D: Socioeconomic & Cultural Influences

13. What role do socioeconomic factors such as poverty and education play in maternal health outcomes?
14. How do cultural practices and beliefs affect maternal healthcare-seeking behavior?
15. What strategies have been effective in improving maternal health in Uganda?

Section E: Recommendations

16. What legal reforms would you propose to enhance maternal health rights in Uganda?
17. What additional measures should the government and stakeholders take to reduce maternal mortality?
18. How can civil society and NGOs contribute to improving maternal health outcomes?

Thank you for your participation